

group comparison. Peri-operative (length of vein treated, laser density, procedure duration, technical failure) and postoperative outcomes (anatomical success, Aberdeen Varicose Veins Questionnaire [AVVQ], Venous Clinical Severity Score [VCSS], recurrence rates) were recorded at 1,6,12&52 weeks.

Results: Inter-group analysis: Statistically significant increase over time was observed in the length of vein treated & laser density delivered; while decreasing trend was observed in median procedure duration (Kruskal-Wallis ANOVA, $p < 0.05$). No significant difference was observed in technical failure, anatomical success, recurrence rates, AVVQ and VCSS scores at 3 months post intervention. Intra-group analysis: AVVQ & VCSS scores demonstrated significant improvement at 3 months compared to baseline (Wilcoxon signed rank, $p < 0.05$).

Conclusion: Technical and clinical efficacy of EVLT in the short term is well established. Operator skills can be readily acquired to deliver efficient & effective service with consistent outcomes.

0624 **AUDIT OF HIP FRACTURE MANAGEMENT AND RECOMMENDATIONS FOR QUALIFYING FOR THE BEST PRACTICE TARIFF**
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Introduction: Improving outcomes following hip fractures has been a constant focus within Trauma and Orthopaedics. Commencing April 2010, the Department of Health set-out standards for a Best Practice Tariff (BPT) (£445 + Market-Forces-Factor) for the management of hip fractures as part of the NHS commitment to “High Quality Care for All”. Patients must be admitted under the joint-care of a consultant orthogeriatrician and orthopaedic surgeon; Time to surgery must be within 36 hours from arrival. Compliance is monitored using the National Hip Fracture Database (NHFD).

Method: We conducted a retrospective audit over 12 months of practices within our Trauma and Orthopaedic department against these new standards to quantify the financial implications of the BPT.

Results: We operated on 85 hip-fracture patients. Potential losses incurred by operations delayed beyond 36 hours were £15,600; from incomplete/incorrect data entry into NHFD were £43,440; from the absence of orthogeriatric involvement were £49,300. Potential gain from reducing hospital stays by 1 day-per-patient plus qualifying for BPT was £91,800.

Conclusion: The BPT offers considerable “real” money incentives. We have compiled recommendations for units to improve their services and gain significant additional income whilst providing higher quality of care for this vulnerable group of patients.

0627 **DO PROPHYLACTIC COMPRESSION GARMENTS REDUCE COMPLICATIONS IN BLOCK DISSECTION?**

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Aims and Objectives: NICE guidelines, 2006, state at least 15 block dissections / surgeon / year. Block dissections performed electively or therapeutically in the axilla or groin, usually for skin malignancy are investigated in this paper. The aim of this study was to determine if a benefit would be derived from compression garments applied immediately post-operatively compared to those applied after the onset of lymphoedema.

Materials and Methods: Prospective data on 2 groups of patients operated on by the same surgeon were reviewed over 2 years.

The use of prophylactic compression garments was routine in 1 group ($n=23$) and not used routinely in the other group ($n=20$) as per protocol in two different trusts. The indications for surgery and complications including infection, readmission and lymphoedema were examined.

Results: The majority of patients were treated for stage III/IV melanoma; other indications included SCC.

Our findings showed a significantly higher rate of complications in those patients not treated with immediate post-operative compression garments.

Conclusions: Compression garments appear to reduce complication rate, particularly lymphoedema. Providing a prophylactic compression garment service could significantly reduce the incidence and cost of post-operative complications in block dissections.

0629 **GALLSTONE PANCREATITIS: OUTCOMES OF POOR COMPLIANCE TO GUIDELINES**

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Aim: UK guidelines recommend ERCP within 72 hours for severe gallstone pancreatitis. Definitive management with cholecystectomy should be performed during the same admission or within 2 weeks. Our aim was to assess management of gallstone pancreatitis in our institution.

Method: Retrospective analysis of all patients admitted between 2000–2010 with a first episode of gallstone pancreatitis.

Results: 67 patients were identified (mean age 35 years [18–87]). The overall mortality was 4% (3/67). 58% (39/67) received interventional treatment for gallstones. 46% (31/67) had cholecystectomy only; 68% (21/31) laparoscopic and 32% (10/31) open. 90% (28/31) had surgery within 6 months, 7% (2/31) within 2 weeks and 3% (1/31) during admission. Median time delay was 90 days [3–365]. 12% (8/67) had ERCP. Only 1 patient had ERCP within 72 hours, 6 patients (75%) during the same admission and the remaining within 6 weeks. 3 patients had ERCP only whilst 5 also had cholecystectomy. 12% (8/67) of patients were readmitted with biliarypancreatic complications on at least 1 occasion (median time interval 10 days [1–122]). There were no readmissions AFTER definitive treatment.

Conclusion: Our data shows poor compliance with UK guidelines resulting in high readmission rates. An increase in resources is required to facilitate availability of earlier treatment.

0631 **THE EFFECT OF PSYCHOLOGICAL STATUS ON PAIN AND SURGICAL OUTCOME IN PATIENTS REQUIRING ARTHROSCOPIC SUBACROMIAL DECOMPRESSION**

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Background: Preoperative depression and anxiety have been linked to poorer postoperative outcomes such as increased pain. Few previous studies have investigated these relationships in patients requiring upper limb orthopaedic surgery. This study aims to explore the relationship between preoperative depression and anxiety and postoperative shoulder pain and function in patients requiring arthroscopic subacromial decompression (ASAD) for impingement syndrome.

Methods: This prospective study investigated a series of ASAD patients in 2009/2010. Mental status, shoulder function and shoulder pain were measured using the Hospital anxiety and depression scale, the Oxford shoulder score and the Pain visual analogue scale. Questionnaires were completed 2 weeks preoperatively and 3 and 6 weeks postoperatively.

Results: 31 patients (20 female; 11 male; mean age 55 years) participated. Preoperatively 9 (29%) patients were anxious, 9 were depressed and 5 were both. No significant correlation was seen between preoperative depression and anxiety and postoperative shoulder pain and function scores. Preoperative anxiety correlated significantly with preoperative shoulder pain ($p < 0.05$). Shoulder pain, function and mental state scores improved significantly by 6 weeks postoperatively ($p < 0.05$).

Conclusion: Mental state improved significantly during the postoperative period. However preoperative mental status did not predict the outcome of ASAD in patients with impingement syndrome.

0632 **THE EFFICACY OF IN-PATIENT ENDOSCOPIC RETROGRADE CHOLAN-GIOPANCREATOGRAPHY (ERCP) SERVICE FOR PATIENTS WITH COMMON BILE DUCT (CBD) OBSTRUCTION**

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